



**Provider Enrollment Agreement
Delaware Screening for Life Program**

Provider/ Physician Name	Facility/Group
Address	Contact
Telephone () Fax ()	E-mail

Individual Employer Identification Number (EIN) # _____

Facility/Group EIN # _____ Site # _____

In order to participate in the Delaware Screening for Life Program (SFL), I, on behalf of this medical office, group practice, Health Maintenance Organization, health department, community/migrant/rural clinic, or other entity, agree to the following:

1. Provider will provide medical services, report data, comply with billing procedures, and follow up with patients as described in the SFL Provider Manual.
2. Provider will obtain a signed medical release form for each SFL client.
3. Provider will provide breast, cervical, colorectal, and prostate health examinations and services within appropriate specialty areas to clients enrolled in SFL.
4. Provider will accept as complete payment the rates established using the current SFL CPT list of reimbursable codes for these services. Provider agrees not to bill SFL clients for covered services.
5. All invoices and required patient data will be submitted no later than 60 days after the date of service. Payment is contingent upon receipt of all required data.
6. Provider will record and report screening, diagnostic, treatment and other required data to the SFL program on standard forms provided for recording this information. Data must be reported in the required format, Bethesda System 2001 for pap results, ACR BI-RADS for mammogram results, AJCC staging for breast biopsy results, and as specified on the data form for colorectal screening results.
7. Provider will place a copy of each client's data forms and medical release form in their permanent record and maintain confidentiality for all SFL clients and their records in accordance this state and federal laws, rules, regulations and SFL guidelines.
8. Provider will schedule clients for appointments and notify them of examination results (positive or negative), any recommended treatment options, and next recommended screenings.
9. Provider will assist the client and SFL staff in securing and coordinating available treatment and diagnostic services not otherwise reimbursable by SFL.
10. Provider will perform all service under this agreement to the satisfaction of the SFL program and in accordance with federal, state and local laws, ordinances, rules and regulations.
11. Provider or the State may terminate this agreement at any time by registered mail for any reason or failure to comply with these requirements.

Provider Signature

Date

Name (Please Print) Title

Director of Public Health Signature

Date

This agreement is to be submitted to and kept on file at the Delaware Department of Health and Social Services, Division of Public Health and will be updated in accordance with State policy.